

REPORT - HIPAA 835 to MHD Com'ty Hosp. mapped fields only

<i>Loop</i>	<i>SegID</i>	<i>HIPAA Name</i>	<i>DT</i>	<i>Req</i>	<i>File</i>	<i>Field</i>	<i>DT</i>	<i>Comment</i>	<i>CommentType</i>
		Health Care Claim Payment/Advice						The RSN as payor sends community hospital payment summary (RSN payments to com'ty hosp.) to MHD for encounter data. mapped to 835-RA. Need to store fields from the 837-claim to populate the 835-RA??	Processing Logic
ST		Transaction Set Header		R				Where does the claim come from & go to?	System Questions
ST 01		Transaction Set Identifier Code	ID3	R				Hard code "835"	Translation
ST 02		Transaction Set Control Number	AN9	R				Compute; Generate from 1 increment by 1 for each TS in a functional group	Translation
BPR		Financial Information		R				BALANCING: (sum of all CLP04-claim payments) minus (sum of PLB prov adj) must equal BPR02-payment amount	Processing Logic
BPR01		Transaction Handling Code	ID2	R				Hard code; "P"=pre-notify to test; else "I"	Translation
BPR03		Credit or Debit Flag Code	ID1	R				Hard code "C"	Translation
BPR04		Payment Method Code	ID3	R				If by check, use "CHK"; if info. only, use "NON"; if EFT, use "ACH"	Translation
BPR05		Payment Format Code	ID10	S				Use BPR05+ only if doing EFT (BPR04="ACH")	Translation
BPR06		Depository Financial Institution (DFI) Identification Number Qualifier	ID2	S				Hard code "01" for US banks	Translation
BPR07		Sender DFI Identifier	AN12	S				Hard code payor's BankID	Translation
BPR08		Account Number Qualifier	ID3	S				Hard code "DA"	Translation

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	BPR09	Sender Bank Account Number	AN35	S				Hard code payor's Account Number	Translation
	BPR10	Payer Identifier	AN10	S				Hard code "1"+payor's Fed TaxID	Translation
	BPR12	Depository Financial Institution (DFI) Identification Number Qualifier	ID2	S				Hard code "01" for US banks	Translation
	BPR14	Account Number Qualifier	ID3	S				if "C", use "DA"; if "S", use "SG"	Translation
	BPR16	Check Issue or EFT Effective Date	DT8	R				needs date conversion	Translation
	TRN	Reassociation Trace Number		R				Need to store ACH ID number (warrant number)	HIPAA Required
	TRN01	Trace Type Code	ID2	R				Hard code "1"	Translation
	TRN02	Check or EFT Trace Number	AN30	R				If BPR04="NON" generate unique ID across all remittance advices; if BPR04="CHK" use check number; if BPR04="EFT" use ACH number	Translation
	TRN03	Payer Identifier	AN10	R				Same as BPR10, in case different payers use the same TRN02 numbers	Translation
	CUR	Foreign Currency Information		S					
	REF	Receiver Identification		S				Req'd if 835 sent to anyone other than payee	HIPAA Required
	REF01	Reference Identification Qualifier	ID3	R				"EV"-receiver ID	Translation
	REF02	Receiver Identifier	AN30	R				Get from 837 NM109-Submitter Identifier	Match Back
	REF	Version Identification		S					
	REF01	Reference Identification Qualifier	ID3	R				Hard code "F2"	Translation

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	REF02	Version Identification Code	AN30	R				Hard code; version number of TARGET system	Translation
	DTM	Production Date		S					
	DTM02	Production Date	DT8	R	RSN_CH_IP_P ay_Sum_v4	Date_Paid	char		
1000A	N 1	Payer Identification		R					
1000A	N 1	Payer Identification		R					
1000A	N 101	Entity Identifier Code	ID3	R				Hard code "PR"	Translation
1000A	N 102	Payer Name	AN60	S				Hard code payor's name: "WA DSHS DASA"	Translation
1000A	N 103	Identification Code Qualifier	ID2	S				Hard code "XV" when PlanID used; else "FI"-federal tax ID	Translation
1000A	N 104	Payer Identifier	AN80	S				Hard code payor's National PlanID when used; else federal tax ID	HIPAA Required
1000A	N 3	Payer Address		R					
1000A	N 301	Payer Address Line	AN55	R				Hard code payor's address	Translation
1000A	N 4	Payer City, State, ZIP Code		R					
1000A	N 401	Payer City Name	AN30	R				Hard code payor's address	Translation
1000A	N 402	Payer State Code	ID2	R				Hard code payor's address	Translation
1000A	N 403	Payer Postal Zone or ZIP Code	ID15	R				Hard code payor's address	Translation
1000A	REF	Additional Payer Identification		S					
1000A	REF01	Reference Identification Qualifier	ID3	R				hard code "2U"-payor's local ID	Translation
1000A	REF02	Additional Payer Identifier	AN30	R	RSN_CH_IP_P ay_Sum_v4	RUID	int		

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1000A	PER	Payer Contact Information		S					
1000A	PER01	Contact Function Code	ID2	R				Hard code "CX"	Translation
1000A	PER02	Payer Contact Name	AN60	S				Hard code payor's adjudication contact for electronic remittance advice	Translation
1000A	PER04	Payer Contact Communication Number	AN80	S				Hard code contact phone #	Translation
1000B	N 1	Payee Identification		R					
1000B	N 1	Payee Identification		R					
1000B	N 101	Entity Identifier Code	ID3	R				Hard code "PE"	Translation
1000B	N 103	Identification Code Qualifier	ID2	R				Hard code "F1"-TaxID, until NPI used.	Translation
1000B	N 104	Payee Identification Code	AN80	R				If prov is person, use SSN, else use emplr-num	Translation
1000B	N 3	Payee Address		S					
1000B	N 4	Payee City, State, ZIP Code		S					
1000B	REF	Payee Additional Identification		S					
1000B	REF01	Reference Identification Qualifier	ID3	R				hard code "PQ"-local ID for payee	Translation
1000B	REF02	Additional Payee Identifier	AN30	R		RSN_CH_IP_Pay_Sum_v4	Prov_Number	char	
2000	LX	Header Number		S					
2000	LX	Header Number		S					
2000	LX 01	Assigned Number	N06	R				Required if > 1 claim per transaction.	System Questions
2000	TS3	Provider Summary Information		S					

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2000	TS2	Provider Supplemental Summary Information		S					
2100	CLP	Claim Payment Information		R					
2100	CLP	Claim Payment Information		R				BALANCING: CLP03-claim charge minus (sum of all CAS service line adjustments) must equal CLP04-claim payment	Processing Logic
2100	CLP01	Patient Control Number	AN38	R	RSN_CH_IP_Pay_Sum_v4	Claim_ID	char	Provider's ID for patient, as received on 837-claim CLM01	HIPAA Required
2100	CLP02	Claim Status Code	ID2	R				map codes; default to "3"-processed as tertiary	Map Codes
2100	CLP03	Total Claim Charge Amount	R18	R	RSN_CH_IP_Pay_Sum_v4	Claim_Charge	money	required	HIPAA Required
2100	CLP04	Claim Payment Amount	R18	R	RSN_CH_IP_Pay_Sum_v4	Reimbursement	money	required	HIPAA Required
2100	CLP06	Claim Filing Indicator Code	ID2	R				Get from 837 - SBR09	Match Back
2100	CLP11	Diagnosis Related Group (DRG) Code	ID4	S	RSN_CH_IP_Pay_Sum_v4	DRG	smallint	Institutional only: required if DRG is used to adjudicate claim	HIPAA Required
2100	CLP12	Diagnosis Related Group (DRG) Weight	R15	S				institutional only, required if DRG is used to adjudicate claim	HIPAA Required
2100	CAS	Claim Adjustment		S					
2100	CAS01	Claim Adjustment Group Code	ID2	R				required if paid amt <> billed amt	Map Codes
2100	CAS02	Adjustment Reason Code	ID5	R				required if paid amt <> billed amt	Map Codes
2100	CAS03	Adjustment Amount	R18	R				required if paid amt <> billed amt	HIPAA Required
2100	CAS04	Adjustment Quantity	R15	S				subtract total claim submitted units (need to store for SVC07) from total claim paid units (units-of-service)	HIPAA Required
2100	NM1	Patient Name		R					

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2100	NM101	Entity Identifier Code	ID3	R				Hard code "QC"	Translation
2100	NM102	Entity Type Qualifier	ID1	R				Hard code "1"	Translation
2100	NM103	Patient Last Name	AN35	R	UND_ConDemog	Surname	char	As it came in on 837 Loop 2010BA NM1	HIPAA Required
2100	NM104	Patient First Name	AN25	R	UND_ConDemog	GivenName	varchar	As it came in on 837 Loop 2010BA NM1	HIPAA Required
2100	NM108	Identification Code Qualifier	ID2	S				Hard code "MR"-Medicaid recip ID or "MI"-member ID	Translation
2100	NM109	Patient Identifier	AN80	S	RSN_CH_IP_Pay_Sum_v4	CID	varchar	Concatenate CID (patient) and RUID (RSN) for unique ID.	Translation
2100	NM109	Patient Identifier	AN80	S	RSN_CH_IP_Pay_Sum_v4	RUID	int	Concatenate CID (patient) and RUID (RSN) for unique ID.	Translation
2100	NM1	Insured Name		S					
2100	NM1	Corrected Patient/Insured Name		S				Required if patient name is corrected from 837 to 835	System Questions
2100	NM101	Entity Identifier Code	ID3	R				Hard code "74"	Translation
2100	NM102	Entity Type Qualifier	ID1	R				Hard code "1"	Translation
2100	NM103	Corrected Patient or Insured Last Name	AN35	S				required if 837 name <> 835 name	HIPAA Required
2100	NM108	Identification Code Qualifier	ID2	S				Hard code "C"-Insured's changed Medicaid recip ID number	Translation
2100	NM1	Service Provider Name		S				required if payee <> service provider	System Questions
2100	NM101	Entity Identifier Code	ID3	R				Hard code "82"-Rendering Provider	Translation
2100	NM103	Rendering Provider Last or Organization Name	AN35	S				required if payee <> service provider	System Questions
2100	NM108	Identification Code Qualifier	ID2	R				Hard code "MC"-Medicaid ID or "XX"-NPII	Translation
2100	NM1	Crossover Carrier Name		S				Any TPL?	System Questions

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2100	NM101	Entity Identifier Code	ID3	R				Hard code "TT"=TPL carrier	Translation
2100	NM1	Corrected Priority Payer Name		S				This segment will be populated if this payer should be paying BEFORE Medicaid pays. The segment prior to this one will be populated if that payer pays AFTER Medicaid pays. The logic to determine this would have to be added to the MMIS.	Electronic COB
2100	NM101	Entity Identifier Code	ID3	R				Verify "PR"	Translation
2100	NM102	Entity Type Qualifier	ID1	R				Hard code "2"	Translation
2100	NM108	Identification Code Qualifier	ID2	R				Hard code "PI"-payer ID or "XV"-Nat'l Plan ID	Translation
2100	NM109	Corrected Priority Payer Identification Number	AN80	R				Need to map to standard ID schema.	Map Codes
2100	MIA	Inpatient Adjudication Information		S				This segment is for inpat. inst. only	Translation
2100	MOA	Outpatient Adjudication Information		S				This segment is for all claims except inpat. inst.	Translation
2100	REF	Other Claim Related Identification		S					
2100	REF01	Reference Identification Qualifier	ID3	R				Send "1W" with PIC; send "SY" with SSN	Translation
2100	REF02	Other Claim Related Identifier	AN30	R		RSN_CH_IP_Pay_Sum_v4	PIC	char	
2100	REF02	Other Claim Related Identifier	AN30	R		UND_ConDemog	SSN	char	
2100	REF	Rendering Provider Identification		S					
2100	DTM	Claim Date		S				required if not all service lines have dates	System Questions

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2100	DTM01	Date Time Qualifier	ID3	R				if range, "232"=Claim Statement Period Start; "233"=Claim Statement Period End	Translation
2100	DTM02	Claim Date	DT8	R	RSN_CH_IP_Pay_Sum_v4	Adm_Date	char		
2100	DTM02	Claim Date	DT8	R	RSN_CH_IP_Pay_Sum_v4	Disch_Date	char		
2100	PER	Claim Contact Information		S					
2100	AMT	Claim Supplemental Information		S					
2100	AMT01	Amount Qualifier Code	ID3	R				With "AU", send sum of claim's lines' payment amounts; with "F5", send patient paid amount	Translation
2100	AMT02	Claim Supplemental Information Amount	R18	R	RSN_CH_IP_Pay_Sum_v4	Recipient_Amount	money		
2100	QTY	Claim Supplemental Information Quantity		S					
2110	SVC	Service Payment Information		S				Support max 999 service lines per claim	HIPAA Required
2110	SVC	Service Payment Information		S				BALANCING: SVC02-submitted service charge minus (the sum of all CAS adjustments) must equal SVC03-service payment	Policy Issues
2110	SVC01	Product or Service ID Qualifier	ID2	R				Store 837 SV101-1, or "NU" for paper UB	Map Codes
2110	SVC01	Procedure Code	AN48	R				Required if adjudicated at service line level.	System Questions
2110	SVC01	Procedure Modifier	AN2	S				professional only: Store all modifiers from 837 SV101	Match Back
2110	SVC02	Line Item Charge Amount	R18	R				Required if adjudicated at service line level.	System Questions

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2110	SVC03	Line Item Provider Payment Amount	R18	R				Required if adjudicated at service line level.	System Questions
2110	SVC07	Original Units of Service Count	R15	S				Used and required only if paid number of units differs from billed number of units; store original units from 837 SV104	System Questions
2110	DTM	Service Date		S				Required if there is no claim date.	System Questions
2110	DTM01	Date Time Qualifier	ID3	R				Hard code; "472" for one date service; "150" for begin of date range; "151" for end of date range	Translation
2110	CAS	Service Adjustment		S				Are there any service level adjustments?	System Questions
2110	CAS01	Claim Adjustment Group Code	ID2	R				Derive group code using logic in I.G., sec 2.2.4 and p. 21, 150.	Map Codes
2110	CAS02	Adjustment Reason Code	ID5	R				Map per EOB TAG	Map Codes
2110	CAS03	Adjustment Amount	R18	R				Must store amounts for all adjustments	HIPAA Required
2110	CAS04	Adjustment Quantity	R15	S				subtract paid units (SVC05) from submitted units (SVC07)	Translation
2110	REF	Service Identification		S				"6R" required if sent on 837.	HIPAA Required
2110	REF01	Reference Identification Qualifier	ID3	R				Hard code; "6R"=Provider's line item number; "G1"=prior authorization number	Translation
2110	REF02	Provider Identifier	AN30	R				we also need PA# at service line level	Processing Logic
2110	REF	Rendering Provider Information		S				We may need to have service provider on each service line level, not just claim level.	Nice to Have
2110	AMT	Service Supplemental Amount		S					
2110	QTY	Service Supplemental Quantity		S					

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2110	LQ	Health Care Remark Codes		S				For EOB codes not linked to funds.	System Questions
2110	LQ 01	Code List Qualifier Code	ID3	R				Hard code "HE", claim payment remark code	Translation
2110	LQ 02	Remark Code	AN30	R				map to codes from EOB TAG	Map Codes
2110	PLB	Provider Adjustment		S				Any adjustments not specific to a claim (provider level)?	System Questions
2110	PLB02	Fiscal Period Date	DT8	R				Needs convert to CCYYMMDD	Translation
2110	PLB03	Adjustment Reason Code	ID2	R				Add provider level EOB-CODE to medical claim; see list of codes IG p165	HIPAA Required
2110	SE	Transaction Set Trailer		R					
2110	SE 01	Transaction Segment Count	N010	R				Compute, number of included segments, including ST, SE	Translation
2110	SE 02	Transaction Set Control Number	AN9	R				Same as ST02	Translation

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Comment Type Legend:

Case Management = "Nice to Have" fields for case reviewers.

Electronic COB = If we do electronic COB, these fields will be needed.

HIPAA Questions = Questions about interpreting the HIPAA Implementation Guides.

HIPAA Required = Required fields in HIPAA that don't seem to be in the legacy system.

Map Codes = Need to crosswalk local codes to standard codes.

Match Back = Fields received on an incoming transaction that must be returned in the response.

Nice to Have = Optional fields that are useful for other reasons.

Policy Issues = Decisions to be made by system experts.

Processing Logic = Logic that needs to be built into either the front end or MMIS.

System Questions = Questions about the legacy systems.

Translation = Only use to program translations.

Column Heading Legend:

"DT" = Data Type

COBOL Data Types Legend:

X(n) - Character data with length of n bytes

9(n) - Integer data with length of n bytes

S9(n) - Signed integer data with length of n bytes

9(n)V99 or 9(n)V9(2) - Numeric data with n decimal digits before the decimal point and 2 decimal digits after the decimal point

S9(n)V99 or S9(n)V9(2) - Signed numeric data with n decimal digits before the decimal point and 2 decimal digits after the decimal point

HIPAA Data Types Legend:

ANn - Free text with length of n bytes

IDn - Coded value with length of n bytes

Nn - Numeric data with length of n bytes

Rn - Real data with length of n bytes

DT8 - Date expressed as CCYYMMDD

TM8 - Time expressed as HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds ((00-99)